

Opioids and the Workplace

An Employer Toolkit for
Supporting Prevention,
Treatment, and Recovery

About the KHC

The Kentuckiana Health Collaborative (KHC) is a non-profit organization comprised of representatives who have a major stake in improving the health status and the healthcare delivery system in Greater Louisville and Kentucky. The KHC creates a space for multiple stakeholders to work collaboratively toward the Triple Aim goals of Better Health, Better Care, and Better Value.

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Disclaimer

This toolkit provides general information on the topic of opioids in the workplace. It should not be taken as legal advice. Please consult an employment attorney to discuss your workplace's unique circumstances before implementing any policies relating to the topics described in this toolkit.

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Executive Summary

Opioids and the Workplace

Opioids are a class of drug that includes prescription painkillers and heroin. Prescription opioids are a widely used method of treating pain. When used under a healthcare provider's supervision and in accordance with opioid prescribing guidelines, they can be an effective treatment. However, they also have a great potential for dependence, development of an opioid use disorder (OUD), and fatal overdose.

Prevention, treatment, and recovery are three types of parallel services that can have a significant impact on minimizing risks associated with opioid use. Prevention involves measures to avoid misuse and dependence by reducing medical and non-medical exposure to opioids. Treatment involves diagnosis and professional treatment of individuals diagnosed with an OUD. Since OUD is a chronic disease, the goal of treatment is a remission of symptoms. Recovery for a person with chronic disease involves active ongoing self-management that often requires the help of biological, psychological, and social supports.

In response to a sharp increase in opioid misuse and opioid-related overdoses, the United States declared a nationwide public health emergency in October 2017. Today, individuals, families, and communities across the nation are still facing significant emotional, social, physical, and financial impacts. Workplaces are no exception, with 70% of them in America reporting feeling the impact of the crisis in multiple ways including safety, absenteeism, productivity, retention, healthcare spend, and hiring.

Employers have an important role in promoting, protecting, and supporting the health and safety of their employees and their families. Fortunately, there are many ways that employers can engage in supporting employees who are facing the challenges of the opioid crisis while also positively impacting their business.

Data Analytics to Understand the Workforce

Employers can utilize their pharmacy and medical data to understand the status of their workforce's substance use disorder (SUD) and OUD risks and trends. The first step is understanding key characteristics of the employee population, including enrollment data, medical and pharmacy spend, top conditions and medication, and total mental health and SUD expenditures. By looking at the appropriate measures, employers can have many of their SUD and OUD related questions answered in relation to prevention, treatment, and recovery, including:

Prevention

- How often are members being exposed to opioids?
- Why are members being prescribed opioids?
- Are members receiving appropriate care to manage their pain?
- Are members who are exposed to opioids at risk?
- Are members overdosing on opioids?

Treatment and Recovery

- How many members have been diagnosed with SUD?
- Are members with SUD accessing treatment?

Healthcare Benefits to Increase Access to Evidence-Based Services

Healthcare benefits should align with evidence-based OUD prevention, treatment, and recovery services to ensure that health plan members are able to access appropriate, timely, and effective care. Employers should compare their current health plan benefits to the following recommendations and identify any opportunities for enhancement. Furthermore, employers should consider coverage limitations, cost-sharing, and utilization management as they relate to these benefits.

Prevention	<ul style="list-style-type: none">• Help employees manage pain• Cover screening in primary care offices• Cover site-of-use disposal• Offer employee assistance programs (EAP)	Treatment and Recovery	<ul style="list-style-type: none">• Provide access for inpatient and outpatient care• Cover medication for opioid use disorder• Provide access to behavioral and mental health services• Cover naloxone to reduce mortality• Improve access to behavioral healthcare through telemedicine• Consider centers of excellence and alternative payment models
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Policies to Transform Culture and Protect the Workplace

Workplace policies can play an important role in determining the culture of a workplace, as well as protecting employers and employees. To facilitate these improvements, employers should consider the following policy recommendations in relation to their respective service.

Prevention	<ul style="list-style-type: none">• Educate employees and supervisors• Create a culture of support• Develop a workplace substance use policy• Implement effective and privacy-sensitive drug testing	Treatment and Recovery	<ul style="list-style-type: none">• Offer leaves of absence and flexible scheduling• Provide support group resources• Develop a return to work policy
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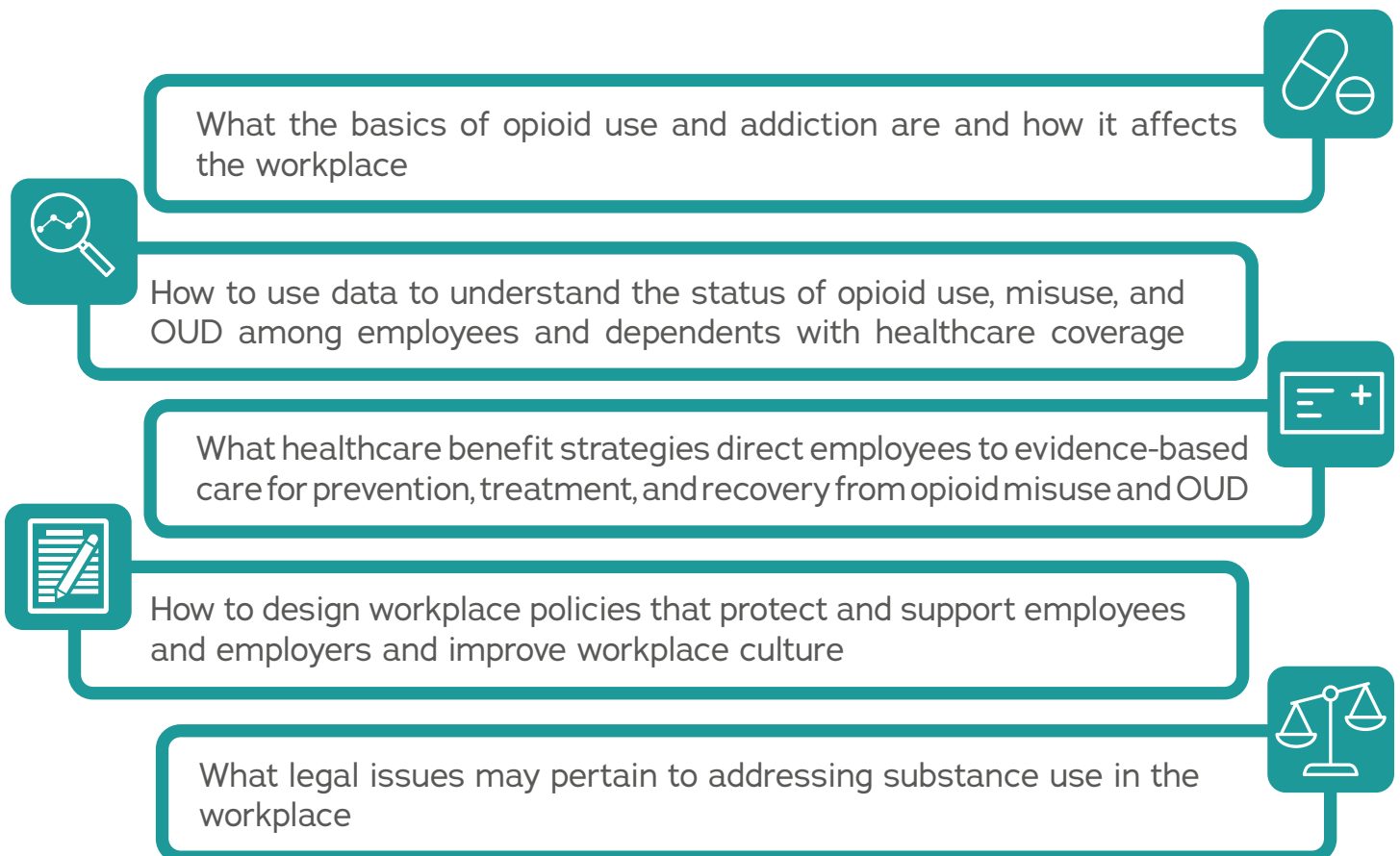
Legal Issues to Consider

As with many workplace interventions, there are also legal considerations. Employers should familiarize themselves with relevant laws, consult their labor and employment attorney, and if relevant, their labor relations team. Some laws that employers should consider are the Health Insurance Portability and Account Act (HIPAA), Americans with Disabilities Act (ADA), Family and Medical Leave Act (FMLA), and the Mental Health Parity and Addiction Equity Act (MHPAEA). Some potential issues include identification and disclosure, intervention and confidentiality, discrimination and reasonable accommodation, and special-industry regulations.

How to Use This Toolkit

Employers play an important role in influencing the health and safety of their employees, their families, and the communities they live in. Taking strides to support employees and their families can have a measurable positive impact not only in their lives, but in the success of a business. With the nation in the midst of an opioid crisis, the employer's role as an agent of change is more important than ever. In the workplace, opioid-related issues are impacting businesses and the safety and well-being of their employees. Acute and chronic pain are prevalent and access to comprehensive care is lacking. Furthermore, a behavioral health care system that does not consistently provide high-quality, evidence-based care can exacerbate rather than alleviate, the problems. In some cases, poor quality addiction treatment can lead to worse outcomes for patients. Outdated workplace policies and culture can contribute to stigma and leave current and potential employees fearful of repercussions associated with seeking help. Addressing opioid-related issues in the workplace is new to many employers and finding solutions can be confusing and complex as most employers do not have expertise in this domain.

This toolkit was developed to provide recommendations and tools for employers to support their employees and their dependents in prevention, treatment, and recovery from opioid misuse and opioid use disorder (OUD). Employers who are on the leading edge of a proactive approach to OUD will be best positioned to achieve optimal employee health outcomes, leading to improved productivity and better business performance. By using this toolkit, employers can expect to learn:



The recommendations presented here are not intended to be a one-size-fits-all approach, nor do they have to be implemented in their entirety, as capabilities for large-, medium-, and small-sized employers greatly vary. Due to these variations, the recommendations should be adapted to each workplace in a way that best suits the organization. Although not all recommendations may be applicable to all employers, all employers can learn from and potentially adopt some of them. Employers should involve a variety of key workplace stakeholders with responsibility for implementing these recommendations: human resources professionals (including Labor Relations teams), benefit managers, counsel, C-Suite and union leaders, operations managers, employees, and subject matter experts.

Employers are encouraged to work collaboratively with their key stakeholders and administrators to make appropriate decisions to best support their employees, dependents, communities, and business. Using these tools, employers can better understand which decisions they should make to achieve the most positive impact to their workforce.

Toolkit Interactivity

This toolkit is also available in an interactive version at www.KHCollaborative.org/opioidemployertoolkit. Both the print and interactive versions of this toolkit will be periodically updated to reflect advancements or changes being made in this field. Employers should keep in touch with the Kentuckiana Health Collaborative to be notified of these changes.

Opioids and the Workplace

Opioids and Addiction

Opioids are a class of drug that includes prescription painkillers and heroin. These drugs are derived from, or closely mimic, the pain-relieving compounds found in the substance opium and can be produced in natural, synthetic, or semi-synthetic forms. Common forms of natural and semi-synthetic opioids include morphine, codeine, heroin, hydrocodone, oxycodone, and hydromorphone. Synthetic opioids include methadone, demerol, and fentanyl.

Prescription opioids are a widely used method of treating moderate to severe, acute, and chronic pain. When used under a healthcare provider's supervision and in accordance with opioid prescribing guidelines, they can be an effective treatment. However, they also have great potential for dependence, recreational misuse, development of an opioid use disorder (OUD), and fatal overdose. These dangers are associated with how and how much of an opioid is taken. Methods of misuse include taking the drug in a way other than prescribed, taking someone else's prescription medication, or taking medicine for the pleasurable effects it provides. Any use of illicit opioids, like heroin, is considered misuse. Negative outcomes related to misuse increase when opioids are ingested in ways other than swallowing, such as being crushed and injected or snorted. These methods deliver an increased concentration of the opioid and amplify the risk of overdose.

Immediate side effects of opioid use can include drowsiness, nausea, constipation, confusion, and dizziness. Serious side effects, often as a result of opioid misuse or opioid interaction with another substance, can include clammy skin, weak muscles, low blood pressure, and slowed breathing. In extreme circumstances, this can lead to a coma or death by overdose.

A person can become physically dependent on opioids when taking them at a high enough dose for more than a few days. Physical dependence involves the body's natural adaptation to regular exposure to the substance, leading to tolerance or withdrawal. Tolerance means a person needs more of the drug to produce the same effect. Withdrawal is a negative series of symptoms that includes nausea, vomiting, diarrhea, agitation, and pain, that occurs when a person stops taking an opioid. There is a difference between physical dependence and the disease of addiction.

Opioid Use Disorder Symptoms¹

An OUD diagnosis is applicable to a person who uses opioids and experiences at least two of the following 11 symptoms in a 12-month period:

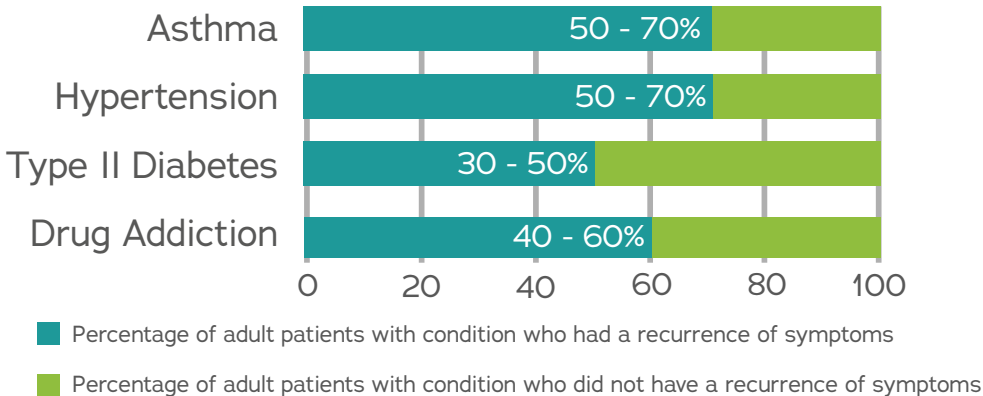
- Taking in larger amounts than intended
- Desire to control use or failed attempts to control use
- Significant time spent obtaining, using, or recovering from the substance
- Craving for the substance
- Failure to meet obligations
- Social and interpersonal problems
- Activities given up or reduced
- Physically hazardous use
- Physical or psychological problems likely caused by use
- Tolerance
- Withdrawal

Tolerance and withdrawal are not considered OUD symptoms when an opioid is being taken as prescribed.

When a person has subjective distress or objective reduction in functioning because of opioid use, they may meet the criteria for OUD. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) categorizes OUD on a spectrum of severity: mild, moderate, or severe. The DSM-5 provides a list of criteria for behavioral health professionals to reference when diagnosing mental health or substance use disorders (SUD). Severe OUD is consistent with the chronic brain disease of addiction. OUD is a chronic and treatable disease requiring medical intervention. Similar to other chronic diseases, it often involves cycles of worsening symptoms and remission.

Although opioids work the same in all brains, not all individuals who take or misuse opioids will develop OUD. A person can become dependent, tolerant, or experience withdrawal on opioids without ever experiencing the symptoms associated with OUD. Complex interactions between a person’s environment and biology present risk and protective factors for individuals in developing OUD and its resulting clinical course. These factors do not determine whether or not an OUD will develop; however, they can interact to minimize or maximize the likelihood of its development.

The Recurrence of Symptoms is Similar for Addiction and Other Chronic Illnesses



SOURCE: McLellan AT, Lewis DC, O'Brien CP, Kleber HD. Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. JAMA. 2000;284(13):1689-1695.

Opioids in the Brain

Opioids work by activating receptors in the body to block feelings of pain. The addictive nature of opioids is derived from their effect on the brain’s natural reward circuitry. Opioids produce an excess of dopamine; a neurotransmitter that contributes to feelings of pleasure and satisfaction. Opioids can produce feelings of relaxation, euphoria, and being “high.” The human brain is wired to repeat actions associated with these feelings and to avoid associated feelings of withdrawal; therefore, this excess of dopamine positively reinforces opioid-taking behaviors and biologically wires individuals to repeat them. With repeated exposures, a person’s brain circuitry and chemical systems are altered, affecting cognitive, emotional, biological, and social functions. Unlike substance misuse, addiction is a chronic brain disease. There are changes in specific areas of the brain which have been found to correlate with the behavioral manifestations we observe in people with addiction. While these brain areas trend back towards normal if the brain is not exposed to the drug of abuse, science has not shown a full return to normal in brains of people who have addictive disease.

Prevention, Treatment, and Recovery

Three types of parallel services for opioid misuse and OUD are prevention, treatment, and recovery. Intervention at each of these levels is important for a complete and effective response to minimizing the risks associated with opioid use. These services can occur at any time during a person's experience.

Prevention

Prevention involves measures to avoid misuse and dependence by reducing medical and non-medical exposure to opioids. Prevention of developing complications once a person has developed addiction can also include harm reduction services that aim to reduce the likelihood of negative consequences or death as a result of opioid use. These can include needle exchanges and naloxone for overdose prevention.

Treatment

Treatment involves diagnosis and professional treatment of individuals with OUD. Evidence-based treatment for OUD can involve several treatment modalities that address biological, social, and psychological issues within the individual. This includes Medication for Opioid Use Disorder (MOUD) and individual and family behavioral therapies. These modalities can be supplemented by recovery support services. As defined through the American Society of Addiction Medicine (ASAM) criteria, treatment can be carried out on a variety of inpatient or outpatient levels, depending on the individual's situation, substance of use, and required intensity of care.

MOUD, commonly referred to as Medication Assisted Treatment (MAT), is more effective in reducing illicit opioid use, keeping people in treatment, and reducing risks of overdose than in treatment without.²⁰ There are three types of approved medications: methadone, naltrexone, and buprenorphine. These three drugs are available under a variety of brand names as approved by the Food and Drug Administration (FDA). Each of these medications works differently, presenting their own risks and benefits, and should be discussed and made available to treat anyone diagnosed with OUD. It is important to note that the use of prescribed FDA-approved MOUD as part of treatment is consistent with the definition of abstinence.

MOUD can be supplemented with behavioral therapies or counseling. Behavioral therapies and counseling services for OUD can help change attitudes and behaviors associated with use, build healthy life skills, and support adherence with other forms of treatment. It can be provided by physicians as part of an individual's medical visit, but some people may require or benefit from specialized counseling services provided in individual or group settings. This counseling can be offered to individuals who are using opioids, as well as their friends and family.

Medication for Opioid Use Disorder (MOUD)

Methadone | Methadone treats withdrawal symptoms, blocks effects of opioids if they are simultaneously ingested, and reduces cravings. It can only be dispensed and administered in federally certified, accredited opioid treatment programs (OTPs.)

Naltrexone | Naltrexone blocks the effects of other opioids and reduces cravings for opioids. It can be prescribed by any licensed healthcare provider and depending on how its administered, can be taken in or out of a provider's office.

Buprenorphine | Buprenorphine treats withdrawal symptoms, blocks effects of opioids if they are simultaneously ingested, and reduces cravings. It can only be prescribed by physicians and advanced practice clinicians that have a federal waiver to do so.

Another potentially helpful supplement to treatment is recovery support services. These services are not clinical in nature but are often provided by trained volunteers or other people who are in recovery. These supports include assistance with navigating systems of care, removing recovery barriers, staying engaged in the recovery process, and providing a source of community.

People with OUD should have access to all of these services at all levels of treatment, allowing them to find the approach that best fits them. However, there is strong science for supporting the effectiveness of MOUD, and it should be considered as the status quo for treatment.

Remission is the goal of medical treatment for chronic disease and involves the person having no signs or symptoms of active disease. While remission is a goal, people with chronic diseases often have periods of worsening symptoms. People who are actively in treatment may not be in remission at all times. Since OUD is a chronic disease, people often need ongoing care at some level.

Recovery

Unlike acute illnesses, recovery for a person with a chronic disease involves active ongoing self-management that often requires the help of biological, psychological, and social supports. The Substance Use and Mental Health Services Administration (SAMHSA) defines recovery as “a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.” The process of recovery is a very personalized process that is built on the individual’s own characteristics and resources and is a much broader concept than medical remission for any chronic disease.¹⁴

The Opioid Crisis

On October 26, 2017, a nationwide Public Health Emergency was declared by the U.S. Department of Health and Human Services in response to the growing crisis of opioid misuse and overdose.¹⁹ Individuals, families, and communities across the nation continue to face significant emotional, social, physical, and financial impacts.

In 2017, opioids contributed to more than an average of 130 deaths per day - a six-fold increase from 1999.⁶ Most of these deaths occurred in individuals between the ages of 25 and 55 – a group primarily of working age adults.²² The White House Council of Economic Advisors estimates that the total economic cost of the crisis in 2015 was \$504 billion, 2.8% of that year’s GDP.²³ Other unintended consequences of this crisis include compromised mental and physical health, as evidenced by an increase in the prevalence of conditions such as neonatal abstinence syndrome, infectious diseases, suicide, and depression.¹⁹ The safety of communities is also threatened with an associated increase in crime and violence, motor vehicle crashes, and child neglect.¹⁹ The causes of this crisis are multi-faceted and have been developing over the course of many decades.

A contributing factor to this crisis is the stigma that persists not only around opioids, but around prevention, treatment, and recovery services. The belief that addiction is a moral failing and fueled by personal choice has been widespread and long-held. This unfortunate and incorrect belief has deterred individuals from accessing services that are necessary to their recovery due to fear of judgment or reprimand. Additionally, this stigma supports the continued separation of addiction treatment from the traditional healthcare system. To reduce this stigma, there needs to be a cultural shift towards understanding addiction as a chronic disease requiring compassion and evidence-based medical intervention.

As the opioid crisis has progressed, a crisis around pain has been co-evolving. Despite there not being an overall change in the number of Americans reporting pain, the number of prescriptions for opioids quadrupled from 1999 to 2014.⁶ In the 1990's, opioids gained popularity as a quick, effective, and first-line method of treating pain. Although opioids can be an effective component of certain conditions' treatment plans, there are also risks. This was demonstrated through the increased incidence of opioid misuse, opioid use disorder, and opioid-related overdose deaths in subsequent years.

In response to the current opioid epidemic, the healthcare sector has placed a heavy emphasis on improving responsible prescribing of prescription opioids. In 2016, the Centers for Disease Control and Prevention (CDC) released guidelines for appropriately prescribing opioids to those who had not previously used them. These guidelines have been successful in reducing inappropriate prescribing, however systemic barriers to accessing comprehensive evidence-based pain management options, and knowledge deficits in healthcare about proper pain care have left limited options for many people with pain.

At the individual level, pain can be a lifelong challenge. At the population level, pain is a significant public health problem. The Centers for Disease Control and Prevention (CDC) reports that in 2016, an estimated 20.4% of US adults had chronic pain and 8% of adults had high-impact chronic pain.⁷ Some groups are disproportionately affected by pain as well as have less access to pain-related treatment. A higher prevalence of pain is associated with increasing age, poverty, rural residence, and unemployment.⁷

Today, a multi-sector approach has been taken to prevent opioid exposure and related overdoses as well as increase access to OUD treatment options. Progress is being made; however, this same approach must be applied to addressing an upstream cause of opioid use – pain. Opioids can be part of an effective treatment plan for certain conditions. However, comprehensive evidence-based pain management, including opioid prescribing and tapering, must be advanced in order to decrease opioid related harms while ensuring people experiencing pain are receiving appropriate care.

Opioids and Pain

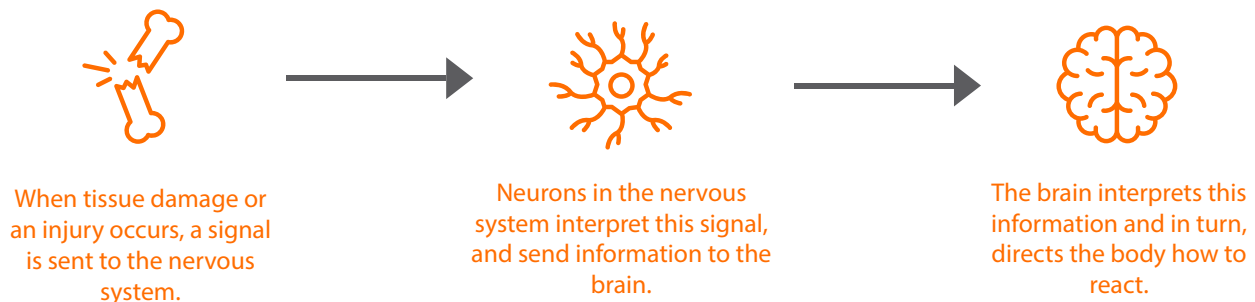
Biology of Pain

Acute pain is an unpleasant yet normal and necessary experience. As part of an evolutionary process, pain can act as a warning sign in response to a harmful stimulus. The unpleasant quality of the sensation prompts individuals to act in a way that limits damage or heals the pain, whether that be withdrawing a hand from a hot stove-top or seeking medical treatment for a broken bone. At its core, pain protects people from incurring damage from adverse internal or external factors. Without pain, people would not be aware of damage that has occurred to their body and be able to appropriately respond. Although pain is a necessary part of the human experience, its persistence can result in a decreased quality of life.

Pain is often a symptom rather than a diagnosable condition. Its classification is complex and different types occur through unique mechanisms in the body. Acute pain is sudden in onset and is a time limited physiological response to tissue damage caused by a variety of conditions such as trauma, burn, musculoskeletal injury, neural injury, as well as pain from surgery or other procedures. Chronic pain often begins as acute pain; however, it is persistent and recurrent, lasting longer than three months. The long held belief is that in some persistent cases, pain can cause neurological changes in the body that lead to pain even without bodily damage. However, new research is challenging this view by identifying improper coordination and combination of care and unaddressed underlying conditions as the cause for persistent pain.

Pain's pathway in the body is complex and involves many systems. Nociceptive pain arises from tissue damage and acts by sending a message from the tissue through the nervous system to the brain. This type of pain is impacted by the body's movement, position, and load. Examples include musculoskeletal injuries such as strains and breaks, or injuries to the skin such as burns and stings. Neuropathic pain arises from damage directly to the nervous system and often presents itself through burning or stabbing sensations. An example of this pain that most people have experienced is hitting a "funny bone," however other experiences result from instances of disease such as multiple sclerosis or opioid addiction, or medical treatments such as chemotherapy. These two types of pain can, and often do overlap. Separate from neuropathic pain is hyperalgesia - pain related to nervous system dysfunction. When experiencing this type pain, an individual's nervous system is communicating signals of pain to the brain in a way that is not consistent with the actual danger of the stimulus. This results in significantly increased severity of pain.

The Pain Pathway



Pain Treatment

The way each person experiences pain is dependent on an intricate network of biological, psychological, and social factors. This network determines pain severity, how it evolves, and what treatment pathway will be effective. An initial evaluation that considers medical and biopsychosocial factors related to a patient's pain is an important component to ensuring comprehensive care. Determined by this evaluation, an individualized, multidisciplinary, and multi-modal approach is most effective for managing pain.

Fundamentally, chronic pain is a chronic injury, and focusing on the origins of pain is the first step to relieving it. A multidisciplinary approach facilitates that process by addressing the different personal aspects that contribute to painful conditions, including biological, psychological, and social factors. A multi-modal approach involves the synergy of different clinical disciplines in a pain treatment plan,

Biopsychosocial Model

Biological | Several biological factors can influence how someone's body responds to injury and therefore experiences pain; including age, genetics, hormones, weight, and damage from the condition causing the pain.

Psychological | The brain centers that cope with pain and mood overlap, so psychological factors such as mood, stress, trauma, and coping skills can all impede or facilitate pain. Conversely, experiencing pain can also have a significant impact on one's psychological state.

Social | Social determinants of health have a role in the progression of pain-related conditions. These include the economic and social factors that influence differences in health among certain groups.

including medication, restorative therapies, interventional procedures, behavioral health approaches, and complementary or integrative health. An individualized approach involves the person experiencing pain being treated in the way that best fits their definition of success and functional improvement.

To accomplish this, integrated care is necessary. Integrated care involves primary, mental health, and substance abuse care being systemically coordinated. Traditional healthcare is often siloed and relies on specialists to treat different aspects of patient's health; however encouraging a team-based approach to a patient's treatment plan can optimize patient outcomes and experience. The complexity of pain treatment not only requires the presence and coordination of a number of providers on this team, but also the right sequence and combination of the care that they provide. Patient navigators can be particularly valuable in coordinating appropriate care. There is evidence to support that this integrated approach reduces the severity of pain and improves function and overall quality of life.²¹

Medication | Multiple classes of medication can be used for managing pain with the goal of ensuring patients have access to the most appropriate treatment to minimize their adverse outcomes while enabling a better quality of life. These medications can include opioid and non-opioid options.²¹

Restorative Therapies | Restorative therapies are focused on movement modalities, including those administered by physical therapy and occupational therapy professionals. Examples include traction, bracing, ultrasound, and therapeutic exercise.²¹

Interventional Procedures | Available as both diagnostic and therapeutic modalities for pain, interventional approaches are minimally invasive interventions that alleviate pain and facilitate repair. Varying in intensity, these procedures can include joint injections, steroid injections, stem cell-based therapy, and more.²¹

Behavioral Health Approaches | Treatment outcomes can be significantly improved by addressing psychological, cognitive, emotional, behavioral, and social aspects of pain. Examples include cognitive behavioral therapies and mindfulness-based stress reduction.²¹

Complementary and Integrative Health | Complementary and integrative approaches to health involve practices such as acupuncture, tai chi, yoga, and massage.²¹ These are typically successful integrated with the other listed modalities.

Barriers to Pain Treatment

People experience many barriers in treating their pain. The number of Americans living with pain is far outpacing the number of physicians who are certified pain specialists. Because of this shortage, an increased responsibility is put on primary care providers to address pain despite inadequate time and resources.

Additionally, insurance coverage and provider reimbursement for integrated, multimodal pain management services are often insufficient. Clinical direction for payer guidelines is often outdated and inconsistent, impeding the delivery of adequate, timely, and affordable treatment while negatively impacting patients

financially and psychologically. Although an individualized, multidisciplinary, and multimodal approach is most effective for managing pain, current payment models do not support this approach.

At a cultural level, there are misunderstandings about what it means to experience pain. Taking a biopsychosocial approach to treating pain often takes significant time and effort on behalf of patients and providers. However, past and present healthcare ecosystems have often perpetuated a more passive, or “quick-fix” approach to pain treatment. This approach does not consider whether the underlying condition causing pain has been resolved or whether the patient’s desired functional status has returned, but rather only if the symptom of pain has increased or decreased.

Workplace Impact and the Employer Role

Not only are individuals, families, and communities experiencing challenges related to the opioid crisis, but workplaces are as well. In fact, nearly 70% of workplaces are experiencing the impact of the crisis.⁹ The stress, co-morbidities, and extenuating difficult circumstances that accompany these individual and community-wide challenges manifest themselves directly through work in multiple ways including safety, absenteeism, productivity, retention, and healthcare spend. General opioid use, tolerance, and dependence also carry workplace risks. They are not strictly associated with workers who have OUD or addiction.

As individuals’ first exposure to opioids is often related to relieving pain, the workplace impact must also be considered. Whether an employees’ duties involve sitting at a desk or repetitive movements for hours per day, pain is a common experience among today’s workforce. Experiencing pain can negatively affect multiple aspects of an individual’s life, including their psychological health, relationships, sleep, physical activity, self-esteem, and work.²¹

Safety | Opioid use can be associated with increased injury in the workplace. Employees using opioids to treat their pain may present safety liabilities when not adequately accommodated.

Absenteeism | People struggling with opioid addiction miss nearly 50% more work than the general workforce.⁴ Acute and chronic pain have similar effects.

Productivity | Substance misuse and related disorders are estimated to cost more than \$400 billion in workplace productivity in the United States.¹⁹ The use of prescription opioids, whether problematic or non-problematic, is associated with a loss in labor capacity.⁸

Retention | 36% of people with SUD and 42% of people with OUD related to pain medication worked for more than one employer in the past year, compared to 25% of the general workforce.⁴ Pain can also severely impact retention, with employees experiencing chronic pain eventually utilizing short- or long-term disability or permanently exiting the workforce.

Healthcare Spend | Healthcare costs for employees who misuse prescription drugs are three times higher than those for an average employee.⁴ Unaddressed acute and chronic pain can also significantly impact an employer’s healthcare spending.

Supporting employees and their families who are in treatment and recovery from SUD or OUD has a positive impact on the lives of employees and the employer.

Employees in recovery have lower healthcare costs, miss less work, and are less likely to leave their employer. These workers average 10% fewer missed work days than the general workforce and have 8% less turnover.⁴

With average cost per hire of over \$4,000, companies can benefit from making direct efforts to retain employees who are facing substance use challenges.^{12,5} In addition to improvement in their business's bottom line and workplace performance, employers should consider the social and communal benefits of adopting a transparent and empathetic approach to SUD and OUD.

Data Analytics to Understand the Workforce

***Refer to Appendix C for detailed measure explanations**

Just as companies otherwise utilize health plan claims data to manage health benefits and services investments to facilitate a healthy, productive workforce, employers can utilize their data to understand the status of their workforce's substance and opioid use disorder (OUD) risks and trends. Data can be used to understand how well current benefits are helping prevent, treat, and support recovery from opioid misuse or OUD. In addition to their own independent data and analytics investments, employers should encourage their health plan or pharmacy benefits manager (PBM) to use this data to inform their product and service portfolio.

Depending on the structure of their health offerings, employers can go to multiple sources to receive their data: health insurer or health plan administrator, pharmacy benefit manager (PBM), data warehouse vendor, or insurance broker. Health plans and data warehouse vendors often have standardized reports that group substance use disorders (SUD) with mental health. If not, included here are a list of questions and measures employers may want to request to better understand their workforce substance use risks and status.

Different data vendors may define the recommended measures differently; it is important for employers to understand the meaning of the measures they receive. For general reference, detailed explanations of each measure can be found in Appendix C.

An employer's data should be examined, at minimum, annually and compared to previous years to identify positive or negative trends. If available, the measures should be compared to national, state, regional, and industry averages. Most measures can be stratified into basic subgroups to identify differences among them, such as: gender, age, employee type (hourly/salaried), relationship to employee (self/spouse/dependent), in-network/out-of-network, health plan types, and prescriber types (dental/medical). When looking at costs associated with each measure, employers should look at the total cost of care in addition to pharmacy or medical health costs separately. Reduced spending in one of these areas can often result in increased spend in the other.

Before an employer can utilize this data, the information must be de-identified within the requirements of HIPAA. Employers should also consult with an employment attorney to confirm compliance with HIPAA and any other applicable federal and state laws that may further restrict the use of claims data or include additional requirements for the de-identification of data.

What if an employer cannot access their data?

Each employer's data analytics capabilities vary based on their size, investments in data and analytics, insurance coverage, and health plan structure. For instance, the fewer employees an employer has, the greater the risk for identification and breach of privacy. Additionally, whether employers are fully-insured, self-insured, or uninsured may present barriers in the data they can access. Integration of pharmacy benefit and health plan data can determine the extent to which employers can relate diagnoses, treatment, and medication data.

Medical and Pharmacy Summary Analytics

The first step to prevention and treatment of OUD is understanding key characteristics of your employee population, including:

Enrollment Data | Number of members, average family size, percentage of males/females, average age, and member type (employees/spouses/dependents)

Medical and Pharmacy Spend | Medical and pharmacy spend including out-of-pocket expenses for members

Top Conditions and Medication | Prevalence, utilization, and total expenditures

Total Mental Health and SUD Expenditures | Mental health and SUD spending as a percentage of total spend

Workers compensation, disability, employee assistance program (EAP), and Family and Medical Leave Act (FMLA) data are also rich sources of mental health and OUD data. This section only focuses on analytics of medical and pharmacy data.

Prevention

By examining claims data related to opioid prescription patterns, employers can identify potential patterns of risk or implement actions to help prevent OUD among their workforce. Employers can use the information obtained from this data to design benefits to ensure that their employees have the support needed to prevent OUD. What is being prescribed, the rate of prescribing, length of prescribing, receipt of prescriptions from multiple sources, and top conditions being prescribed provide valuable insight into the status of opioid use in the employer's workforce. Employers may wish to stratify this data into additional subgroups.

How often are members being exposed to opioids?

Before exploring prescription patterns, employers should start with a basic look at the prevalence of opioid prescribing for pain control. To understand prescribing patterns across different types of opioids, request Morphine Milligram Equivalents (MME) per opioid, length of prescription, and whether the opioid is long-acting versus short-acting.

Measure to Request:

- Opioid Prescriptions

Why are members being prescribed opioids?

It is important to understand which conditions are correlated to opioid prescribing in order to fully understand prescribing patterns. This includes the top conditions that opioid prescriptions are written for and the rate per condition. This information can help employers understand why their workforce is receiving opioids and evaluate alternative options for non-opioid treatment for these conditions.

Measure to Request:

- Top Conditions for which Opioids are Prescribed

Are members receiving appropriate care to manage their pain?

Pain is a symptom rather than a diagnosable condition. The condition for which a member is experiencing pain determines the best clinical pathway for them to receive care. For this reason, examining claims data to evaluate the quality of pain treatment is challenging.

To begin, employers can consider the top conditions for which opioids are prescribed. An evaluation of the IBM® MarketScan® research database revealed that from 2016-2018, the top three conditions for which opioids are prescribed in Kentucky were back pain, arthritis and diabetes. Employers can also request this metric for their own members. Employers can ask for an evaluation of the types and sequences of pain management care that members are receiving to learn useful insights into whether or not comprehensive evidence-based pain treatment is the standard.

Additionally, employers can review claims data to learn if members using opioids long-term are receiving regular follow ups and assessment to monitor their condition, functional outcomes, and opioid use. Employers can also learn the rate of members who are receiving referrals for non-pharmacological therapies. Pharmacologic therapies can be clinically appropriate for treating pain, but should be supported by the use of nonpharmacologic therapies if appropriate.

Long Term Opioid-Therapy Measures to Request:

- Follow Up Visit Quarterly
- Quarterly Pain and Functional Assessments
- Referral for Non-pharmacological Therapy

Are members who are exposed to opioids at risk?

Prescription opioid use is not inherently dangerous. The risk lies in how, how much of, and how long the opioids are taken. Although health plan data cannot identify how members are taking opioids, it can provide insight into the other two factors. Key indicators can give insight into the questions employers may have around prescribing patterns within their health plan and how those patterns may support or deter opioid-related risks. Pharmacy and medical claims data can also give insight to patterns related to overdose or the risk of it.

Measures to Request:

- Use of Opioids at a High Dosage
- Opioid Total Days Covered
- Opioid Lag Days Between Prescriptions
- Use of Opioids from Multiple Providers

Are members overdosing on opioids?

Although capturing definitive information on opioid overdose within a population is difficult, certain measures can help indicate the prevalence of overdose or situations related to it.

Measures to Request:

- Opioid Overdose Rescue (Naloxone) Prescriptions
- Opioid Overdose/Poisoning
- ER Visits due to Overdose
- Concurrent Use of Opioids and Benzodiazepines

Treatment and Recovery

Analyzing pharmacy and medical data can inform employers about SUD diagnoses and their concurrent treatment patterns. Again, this data can be further stratified to be more informative.

How many members have been diagnosed with a substance use disorder?

Although likely an underestimate of how many health plan members are truly struggling with substance misuse or SUD, identifying how many individuals have been clinically diagnosed is an important step for employers to understand the breadth and severity of their workforce and dependents' situation. For further insight, employers should request a breakdown of SUDs by type.

Measures to Request:

- Substance Use Disorder Diagnoses
- Alcohol Use Disorder Diagnoses
- Opioid Use Disorder Diagnoses

Are members with a substance use disorder getting treatment?

Not all health plan members who are diagnosed with a substance use disorder will access treatment. Employers should analyze how many diagnosed members receive treatment to understand any barriers to accessing treatment. For further insight, employers should look at a breakdown of the types and levels of treatment their members are accessing. Additionally, a look at what kind of treatment is being utilized can provide valuable insight into whether or not members are getting evidence-based treatment.

Measures to Request:

- Identification of Alcohol and Other Drug Services
- Use of Pharmacotherapy for Opioid Use Disorder
- Counseling on Psychosocial and Pharmacologic Treatment Options for Opioid Addiction
- Follow-Up After High-Intensity Care for Substance Use Disorder

Quality Outcomes

It is clear that addiction treatment and recovery outcomes are highly individualized. Ideally, each individual will receive the right care, at the right place, at the right time for the optimal chance at a good outcome. What is not clear is how to adequately measure these outcomes. National standards are lacking. Addiction treatment programs have historically been siloed from other medical care, and models for recovery from SUDs do not exist as they do for other chronic diseases. Experts hold various opinions on what these outcomes look like and how they can be adequately measured. National and state leaders in healthcare quality measurement are working towards identifying these measures, and employers are well-suited to be influential in these discussions. This toolkit will be updated as these measures are made available.

Healthcare Benefits to Increase Access to Evidence-Based Services

Health benefits should align with evidence-based opioid use disorder (OUD) prevention, treatment, and recovery services to ensure that health plan members are able to access appropriate, timely, and effective care. Employers should compare their current health plan benefits to the recommendations below and identify any opportunities for enhancement. As purchasers of services from these entities, employers are in a position to dictate that they will only pay for evidence-based healthcare services. Data analytics and medical best practice standards can help inform these decisions.

Employers should consider the following design characteristics when evaluating their healthcare benefits and recommendations presented in this toolkit.

Coverage Limitations | The severity and complexity of a member's disease can affect the characteristics of their needed services. Due to the chronic nature of substance use disorders and pain, coverage limitations on lengths of stay, number of visits, or associated spend can become barriers to treatment. Furthermore, member access to high quality and appropriately located services can be impacted by in-network vs. out-of-network providers.

Cost-Sharing | Costs associated with prevention and treatment for OUD and pain can be a significant barrier for members to access the services that they require. A review of the health plan's cost-sharing requirements, such as co-payments, coinsurance, and deductibles, around these services can help assess the possible magnitude of this barrier. These requirements should be considered in the context of employee income and cost of living.

Utilization Management | Utilization management assesses the appropriateness of a service before it is provided using evidence-based criteria or guidelines to approve or deny services. The appropriate application of utilization management is an important consideration for benefits related to OUD and pain. Prospective, concurrent, and retrospective reviews of services and claims can influence a health plan member's access to treatment as well as protect against health care fraud, waste, and abuse. Employers should examine the structure of these reviews, the frequency and justification of denials and approvals, and align prior authorization requirements to ensure that individuals get timely access to quality care.

Network Adequacy | Network adequacy refers to whether a health plan covers providers that sufficiently allow members to receive timely, quality, and convenient care. Inadequate provider coverage can impede care, leading members to absorb significant financial costs in order to get care specific to their needs. When evaluating network adequacy for care related to prevention, treatment, and recovery services and a biopsychosocial model of pain treatment, employers should consider standards based on physician availability, geographic accessibility, and clinical appropriateness.

Prevention

Help Employees Manage Pain

As is true for the treatment of substance use disorders, treating pain requires an individualized, multidisciplinary, and multimodal approach. Employers should aim to include a broad spectrum of pain treatment modalities in their health plan and take special care not to create or support barriers to their use. Coverage limitations, cost-sharing requirements, utilization management, and network adequacy for these benefits should be considered. Employers should consider weighing these variables against how opioids are covered to understand how and why opioids may have historically been prescribed more prevalently than these alternatives. Special attention should be paid to both medical and dental plans.

Dental Plans

Despite most dental pain being acute in nature and manageable with non-opioid analgesics, dentists are among the top prescribers of opioids in the U.S.¹⁷ This is particularly true among adolescents ages 10-19. A 2019 study in the Journal of the American Medical Association found that dentistry accounts for approximately 25% of first-time opioid prescriptions in this population.¹¹ Exposure to opioids earlier in life is associated with an increased risk of opioid misuse and opioid use disorder.

Many pain management modalities have been proven to provide the same or better pain relief benefits as opioids without the associated risks, excluding some specific clinical conditions. Health plan coverage of these treatments can help prevent OUD and opioid related consequences by reducing the likelihood of an initial exposure to prescription opioids. In some instances, health plan members are constrained by what their health plan will cover as opioids have historically been less expensive than other pain management treatment such as physical therapy.

Although there are numerous risks associated with opioids, there are some situations where they are necessary. For instance, opioids may be appropriate when used for cancer and end-of life patients among other conditions. Comprehensive pain assessment, management, and prescribing techniques are largely a responsibility of health care providers. However, employers can design their benefits to not incent opioid prescribing and to provide coverage of non-opioid options.

Pain management modalities to consider for health plan coverage include:

Medication | Acetaminophen, NSAIDS, Select anticonvulsants and antidepressants, Musculoskeletal agents, Antianxiety medications, Topical agents, Opioids

Restorative Therapies | Physical/occupational therapy, Chiropractic care, Transcutaneous electric nerve stimulation (TENS), Massage therapy, Traction, Therapeutic ultrasound

Interventional Procedures | Local anesthetics (Peripheral nerve injections, Sympathetic nerve blocks, Facet joint nerve block and denervation injection, Trigger points), Steroid injections (Epidural injections, Joint injections), Medication pumps, Radiofrequency ablation, Neuromodulation, Cryoneuroablation, Vertebral augmentation, Regenerative and stem cell-based therapies, Interspinous process spacer devices

Behavioral Health Approaches | Cognitive behavioral therapy (CBT), Acceptance and commitment therapy (ACT), Mindfulness-based stress reduction (MBSR), Self-regulatory or psychophysiological approaches

Complementary and Integrative Health | Acupuncture, Massage and manipulative therapies, Mind-body exercise (ex. yoga, tai chi)

Pain Management Innovation

There are other promising practices for pain management. However, they are not always considered evidence-based by health plan standards. Consequently, they may not always be readily available for addition to health plan coverage. Employers should stay up to date on innovative technologies in this area and initiate regular conversations with their health plans regarding their support of these innovations.

Cover Screening in Primary Care Offices

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based approach to identifying high-risk substance use behaviors that is recommended to be conducted in primary care settings.¹³ Identification of risky substance use can help providers intervene with behaviors prior to the development of SUD or OUD. SBIRT is both an effective and cost-effective approach to the prevention of OUD and related harms. This service should be covered by your health plan and administered yearly to health plan members.

SBIRT

The Kentuckiana Health Collaborative has created resources for implementing SBIRT. Although intended for primary care providers, employers may consider reviewing these resources to become informed and initiate conversations with their health plans. View them at www.KHCollaborative.org/sbirt/.

Cover Site-of-Use Disposal

After being prescribed a prescription opioid, many people are left with an excess of unwanted, expired, or unused doses. These doses are often left in the home, available to be accidentally or intentionally misused by anyone who has access to them, a process called diversion. In fact, half of those misusing prescription opioids obtained them from a friend or family member for free.¹⁶ Safe disposal of prescription opioids can help reduce the likelihood of this occurring.

There are many ways to safely dispose of medications including medicine take-back options and site-of-use disposal. Improper disposal can lead to environmental contamination or sustained access to

the medication. One way to help people avoid confusion around proper disposal methods is to provide site-of-use disposal technologies. Multiple technologies exist that can be provided by a pharmacist or doctor and taken home to dissolve or neutralize excess prescription opioids. Employers should consider covering these technologies as part of their benefits.

Offer Employee Assistance Programs

Employee Assistance Programs (EAP) are intervention programs that offer a variety of services to assist employees who are having personal or work-related problems. These programs can play an important role in assisting employees or their dependents who may be facing substance use issues by providing a confidential and easily accessible option for receiving necessary services. EAPs are separate entities from employers, meaning that any interaction with employees is private and not reported to the employer unless the employee authorizes it. EAPs can be voluntarily accessed by employees. Supervisors and managers can also initiate referrals in response to performance and conduct issues or identification of drug misuse or addiction. EAP services can include:

- **Crisis Intervention**
- **Assessment**
- **Treatment Referral**
- **Short-Term and Follow-Up Counseling**
- **Treatment Monitoring**
- **Supervisor and Management Training**

EAP models and services can vary widely. When selecting an EAP, employers should consider how each option fits their budget, workforce, and general support and health-related goals. Employers should insist that their EAPs screen for risky substance use behaviors and provide referral services to evidence-based treatment programs. If an employer has the capacity, integrating an EAP at the worksite can help increase utilization, referrals, and care coordination.

EAPs are an added expense to employers, but show measurable cost-savings benefits when implemented. Research shows that for every dollar invested in an EAP, employers have a return on investment ranging from \$3 to \$10.³ An added benefit to EAP implementation is its availability to all employees, not just those who are covered by employer-sponsored health insurance.

Treatment and Recovery

Provide Access to Inpatient and Outpatient Care

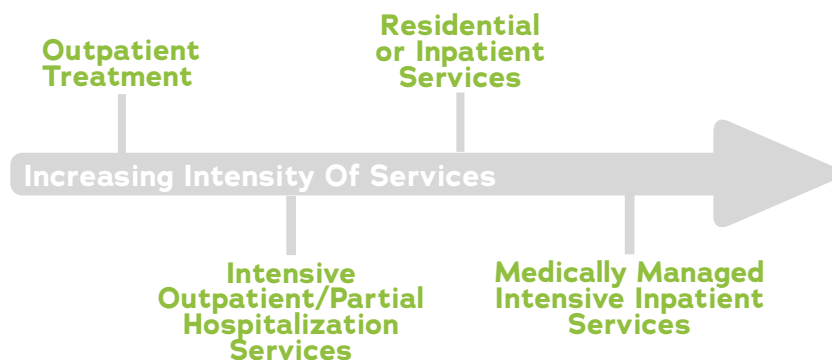
After a SUD is diagnosed, ease of access to timely, high quality treatment is critical to initiate remission. Treatment of SUDs is a highly individualized process that often requires multiple treatment approaches. The inclusion of a variety of treatment modalities in the health plan can help improve the likelihood of members recovering.

Care for SUD can be carried out in a variety of settings and types of facilities, typically identified by types of treatment, length of stay, and intensity of treatment. It is important for members to be placed in the most appropriate level of care for their condition, situation, and goals as determined by the American Society of Addiction Medicine's (ASAM) Levels of Care. A member's level of care is determined by a

provider after a diagnostic evaluation and comprehensive assessment. The assessment could be done by a primary care provider, mental health professional, or treatment facility covered by the health plan. There is no right course to moving between levels of care. To ensure members will have access to the treatment that they require, the health plan should cover all levels of care.

ASAM Levels of Care

There are 10 total levels of care, encompassed by four broader levels. Learn more at <https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/>



Coverage limitations, cost-sharing requirements, and utilization management should be especially considered when designing benefits for inpatient and outpatient treatment. Employers should critically evaluate the financial and health-related impact that these components would have on their specific employee population based on income, location, and other social characteristics. Additionally, employers should require their health plans to examine network adequacy for treatment at the various levels of care and administration of evidence-based modalities.

Components of Care⁵

The US Surgeon General recommends consideration of the following characteristics when looking for well-constructed treatment programs:

- Personalized diagnosis, assessment, and treatment planning
- Long-term disease management
- Access to FDA-approved medications
- Effective behavioral interventions delivered by trained professionals
- Coordinated care for co-occurring diseases and disorders
- Recovery support services

✓ Provide Access to Behavioral and Mental Health Services

When compared with the general population, people with OUD are more likely to have a mental health disorder. Conversely, people with mental health disorders are more likely to have an OUD.¹⁸ An integrated approach to addressing these co-occurring conditions is important to fully supporting an individual's recovery. For most people, a combination of medication and counseling is demonstrated to be the most effective method for promoting health and recovery. As with any chronic disease, treatment and recovery for behavioral health disorders are highly individualized processes. Necessary treatment methods, as well as their duration and frequency, can vary greatly among those affected.

Pain and psychological health are also closely intertwined. An individual's experience with pain can be

strongly influenced by psychological factors, including its duration and severity, as well as the individual's treatment adherence. The experience of pain can lead to increased psychological distress.

Employers should consider closely evaluating their behavioral and mental health offerings. Medical and mental health services should be adequately covered in accordance with the Mental Health Parity and Addiction Equity Act. (MHPAEA). Network adequacy is important when evaluating coverage. In Kentucky, the integrated care needed to address co-occurring conditions is not widely adopted. Therefore, primary care providers who encounter patients with these conditions are challenged with assessing, referring, and managing patients' behavioral health needs.

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 requires the same approach to benefits for mental or SUD services that are available for medical/surgical care. The law does not require that health plans cover MH/SUD diagnoses, treatments, or services but rather requires health plans that do offer these benefits to do so equitably. The regulation applies to:

- Co-pays, coinsurance, and out-of-pocket maximums
- Limitations on service utilization
- Use of care management tools
- Coverage for out-of-network providers
- Criteria for medical necessity determination

Learn more at https://www.cms.gov/ccio/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet.html.

Cover Medication for Opioid Use Disorder

Three medications for the treatment of OUD have been approved by the Food and Drug Administration (FDA): methadone, buprenorphine, and naltrexone. Evidence suggests that treatment plans that include these medications are more effective for reducing early deaths, medical complications, improving day-to-day function, and sustaining long-term recovery than treatment plans without.³ Those seeking treatment for OUD should be offered access to all of these medications as well as any needed behavioral therapies and recovery support services. Healthcare providers can assist members in selecting which treatment option, or combination thereof, is best suited for their needs.

Coverage limitations, cost sharing requirements, and utilization management should all be reviewed as possible barriers to MOUD access. Employers should consider placing MOUD on a lower or lowest cost tier to reduce financial burden. Additionally, receipt of MOUD often requires physician office visits, so elimination or reduction of co-payments for associated visits could be beneficial. Network adequacy can also play a role in health plan member's ability to receive MOUD, since health care providers must maintain certain credentials to administer some forms of MOUD. Employers should have their plans ensure there is an adequate network of providers who administer MOUD.

Cover Naloxone to Reduce Mortality

Naloxone (also known as Narcan or Evzio) is a drug that can be administered during an overdose that temporarily stops many of its life-threatening effects, such as sedation, loss of consciousness, and suppressed breathing. Anyone who is misusing opioids is at risk of an overdose, and naloxone administration can be the immediate intervention that is the difference between life and death. Greater access to naloxone and education about its use are shown to reduce overdose deaths.¹⁸

Naloxone is available at most pharmacies without a prescription. The drug is not intended for only personal use. People who fear that their friends, family, or general members of their community are in danger of overdosing are encouraged to carry the drug. Those administering naloxone should call emergency services. Kentucky's Good Samaritan Law protects people who call for help in an overdose situation from criminal prosecution. Whether utilized personally or for others, the benefit of having naloxone available is unquestionable. Employers should remove cost-sharing requirements in their health plan to improve access to naloxone and be advised that increased spend and utilization of this drug is a positive indicator of reducing likelihood of fatal overdose.

Improve Access to Behavioral Health Care Through Telemedicine

Telemedicine is a promising service in treating and supporting recovery for individuals with SUDs and acute or chronic pain. Telebehavioral health, both web and mobile, expands access to quality, timely, and evidence-based services, including screening, treatment, and consultation. These services are useful in navigating significant barriers to treatment, including transportation to facilities, privacy, missed time from work, and childcare.

Telemedicine services can be offered as part of a health plan package or directly through vendor relationships. Employers should consult both their health plans and pharmacy benefit managers to learn about the telemedicine platforms that they currently use, what types of services are offered, adequate reimbursement rates, and the quality of care demonstrated.

Consider Centers of Excellence and Alternative Payment Models

Employers should consider steering their members to Centers of Excellence (COEs) for comprehensive-integrated pain management and addiction treatment. COEs are institutions that have demonstrated an exceptionally high level of expertise, resources, and outcomes for clinical areas of focus. Employers should talk to their health plan about COE options for their workforce.

Additionally, employers should consider talking to their health plans and consultants about payment reform models. Alternative Payment Models (APMs) are a payment approach that provides a different framework for paying for high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

Bundled payments are a type of APM that provides a single, comprehensive payment covering all of the services involved in a patient's episode of care. Several new bundled payment models have recently

emerged for SUD, including OUD. Some examples of some of these new bundled payments include the Patient-Centered Opioid Addiction Treatment (P-COAT) and Addiction Recovery Medical Home (ARMH).

Alternative payment models also exist for many painful conditions. To improve outcomes related to these conditions and ultimately mitigate pain, employers should consider exploring models that align with both their health plan members' top conditions and top conditions for which opioids are prescribed.

The benefits of these outcome-driven, complementary, and integrative pain management and addiction treatment payment reform strategies for self-funded or financially at-risk organizations may lead to significant cost-savings to the plan when compared to conventional care models. The weaving of plan design, network adequacy and utilization management policies can be challenging to health plans and purchasers. There are an increasing number of new strategies for employers to bring these new models of care to their healthcare benefits.

Policies to Transform Culture and Protect the Workplace

Prevention

✔ Educate Employees and Supervisors

Educating employees on opioid use and associated risks can help prevent the likelihood of their misuse of opioids as well as its potential consequences. The benefits can also extend to the community, as employees can educate their families and friends. This education should focus not only on general topics related to opioid use, but also how substance and opioid use is handled in the workplace. Potential topics to cover include:

- **Relationship between pain and opioids**
- **Risks of opioid use**
- **Alternative methods to opioid use**
- **Company approaches to addiction**
- **Opioid overdose prevention and response**
- **Safe disposal of prescription opioids**
- **Helpful resources for themselves, coworkers, or family members**

Educating supervisors and managers can provide many of the same benefits as educating employees, and also ensures that supervisors and managers are well-equipped to manage opioid-related situations. In addition to the previous topics, supervisor education should ensure content mastery and include topics such as:

- **Workplace substance use and drug testing policies**
- **Laws and regulations on prescription drug use at work**
- **Signs of impairment and factors that may support drug testing**
- **Stigmatizing language and effective communication**

Methods of communicating information to employees can be largely dependent on the workforce's size, culture, and employer resources. To ease implementation, employers should consider utilizing their existing communication channels. Additionally, they may consider adoption of existing targeted training programs and messaging from campaigns such as National Prevention Week, Rx Awareness, Choosing Wisely, or National Take Back Days.

Workplace Naloxone Programs

In addition to educating employees on opioid overdose response, employers may consider implementing a naloxone availability program in the workplace. The Center's for Disease Control and Prevention (CDC) has a guide to aid in this decision, "Using Naloxone to Reverse Opioid Overdose in the Workplace: Information for Employers and Workers." See it at www.cdc.gov/niosh/docs/2019-101/default.html.

✓ Create a Culture of Support

Creating a culture of support in the workplace can help reduce the risk of employees being exposed to opioids, as well as increase their likelihood of seeking help and treatment. By creating and reinforcing a culture of support around opioid- and substance-related challenges in the workplace, employees will feel more empowered to seek help.

Integration of substance misuse prevention messaging into existing workplace wellness programs can help build this culture without the need for many additional resources. This messaging should focus on providing resources to employees, whether through a company EAP or local social support and treatment services, as well as conveying employer support. Communicating trust and openness around the subject of SUD and OUD can help reassure employees that their employer has their best interest in mind and can help them access necessary resources. Furthermore, employees will be better equipped to make healthcare decisions, seek help when needed, and navigate treatment. As part of this messaging, employers should pay special attention to the use of non-stigmatizing language. Stigma creates issues of trust among people who have SUDs and creates negative perceptions of the disease. The Substance Abuse and Mental Health Services Administration (SAMHSA) has a guide for appropriate language, “Words Matter: How Language Choice Can Reduce Stigma.”



Promotion of an employer’s culture and policies toward SUD can also serve as a valuable recruitment and retention tool. Going public with workplace policies and benefit changes in support of prevention, treatment, and recovery can position employers in their community as a champion of compassionate and transparent employment. Employees who feel well-supported by their employers, regardless of what personal challenges they may be facing, will be more inclined to stay with their employer.

In addition to supporting current employees, employers should consider partnering with organizations and programs to hire individuals who may already be in recovery. Individuals in recovery are often highly motivated to succeed and are a potentially untapped group of quality employees, available at a time when unemployment is at record lows. Programs such as Work Opportunity Tax Credits (WOTC) and KY Federal Bonding are in place that benefit employers who hire individuals with barriers to employment. Additionally, other programs exist that partner employers with prospective employees who are in recovery. Employers should consider reaching out to state and local career centers to better understand these programs, as well as explore community or non-profit organizations dedicated to this cause.

Develop a Workplace Drug and Alcohol Policy

Developing a workplace drug and alcohol policy with clear expectations around substance use is an important step in protecting both the employee and the employer. Historically, workplace substance use policies have adopted a zero-tolerance approach. Taking a supportive approach in this policy can benefit employees and employers. For example, in comparison to the general workplace, employees who are in recovery from SUD miss fewer work days and have a higher retention rate.⁴ This policy should focus on being recovery-friendly, striking a balance between supporting and retaining employees who are seeking treatment or in recovery, while also enhancing safety. Employees should sign this policy at the initiation of employment to ensure that both parties are well informed of the terms that are being set forth. A well-designed substance use policy is the foundation for workplace conduct around substance use, as well as legal protection in the case of workplace substance-related incidences. For companies with collectively bargained employee groups, employers should involve the labor relations team. All companies should consult with legal counsel. A drug and alcohol policy should include:

- Policy Rationale and Goals**
 - Reason for having a policy
 - Intended outcomes of the policy
 - How and with whom the policy was developed

- Expectations and Compliance**
 - Employee positions included
 - When and where the policy applies
 - Expected employee behaviors
 - Prohibited behaviors and substances
 - Drug testing procedures

- Consequences and Appeals**
 - Consequences of a policy violation
 - Process for determining violations
 - Process for employees to appeal a violation if desired

- Benefits and Assurances**
 - Methods of helping employees comply with the policy
 - Acknowledgment of covered standards of care in health plan
 - Resources for employees (prevention, treatment, and recovery)
 - Employee rights and processes for taking leaves of absence or flexible scheduling
 - Employee confidentiality and privacy protections
 - Fair and consistent implementation policies

Implement Effective and Privacy-Sensitive Drug Testing

Drug testing programs can be valuable tools for deterring drug use, preventing drug-related incidents, and reducing associated risks. Some employees may view them as intrusive, but some employers are required to administer them by state and federal laws. Thoughtful and targeted construction of a program is critical for ensuring compliance, effectiveness, and employee privacy.

In the instance of a positive test, employers have many considerations. Legal, prescription drug use can yield a positive result on a drug test and may be protected by the Americans with Disabilities Act

(ADA). These cases may require workplace accommodations. In the case of confirmed illegal drug use, employers should consider offering employees a chance to access treatment and initiate their recovery as opposed to immediate termination. Employers should also be advised of differences between tests indicating immediate impairment on the job and tests that indicate past use. When developing a drug testing program, there are many components that should be considered:

Time of Administration | Drug testing can be implemented at multiple points in employment: pre-employment, random, post-accident, when there is suspicion of influence, or as part of an annual physical. Employers should consider keeping drug testing frequency at the minimum required to ensure safety.

Drug Panels Tested | Many different drug panels exist. A drug testing panel indicates the number of substances that are being tested for and can range from five to 12. Employers should consider their industry and applicable laws, regional drug use patterns, and workplace culture when deciding how comprehensive a drug testing panel should be.

Test and Result Processing | Where drug tests are carried out and who evaluates them are critical components to protecting employers and employees both in testing efficacy and in case of legal challenges. Laboratories processing drug test results should be certified by the U.S. Department of Health and Human Services or a state agency. After results are processed, they should be evaluated by a medical review officer (MRO). Receipt and processing of results must be conducted within the same agency.

Confidentiality and Privacy | Drug test results must be carefully protected. They should be handled either by an EAP or designated employee who is well trained in the company's confidentiality protocols, as well as relevant regulations. Records for all drug tests and their corresponding justification should be securely maintained in employees' medical files, not personnel files. Additionally, employees should have access to their drug test results.

Some industries may be required to implement a Drug Free Workplace Program which incorporates specific guidelines for workplace drug testing. The Substance Abuse and Mental Health Services Administration (SAMHSA) provides general guidance on this program at www.samhsa.gov/workplace/toolkit.

Treatment and Recovery

Offer Leaves of Absence and Flexible Scheduling

When accessing treatment for OUD or supporting a family member, employees may need to take a leave of absence or adopt a more flexible work schedule. For example, appointments for counseling or receipt of Medication for Opioid Use Disorder (MOUD) may interfere with their regular work schedule. Accommodating these requirements can help support the employee in their treatment and recovery from OUD.

Privacy can be a concern for employees in need of scheduling accommodations. To mitigate this, employers should ensure that information on how to apply for a leave of absence is readily available and that administrators are well-versed in employee rights. Eligible employees may take up to twelve weeks of unpaid leave for their or their family member's serious health condition under the Family and Medical Leave Act (FMLA).

Provide Support Group Resources

A workplace support group can be an effective tool for employees dealing with substance use challenges. Although privacy concerns can keep employers from facilitating support group meetings, employers can support these gatherings by offering a space for employees to independently convene.

Employers can also help in connecting employees to external support group resources. Multiple organizations exist that help in either determining a support group curriculum for a new group or welcoming people into existing groups. Much like treatment, the philosophy and success of the group are largely dependent on the individual. The Substance Abuse and Mental Health Services Administration (SAMHSA) has information on many of these programs at <https://findtreatment.samhsa.gov/>.

Develop a Return-to-Work Policy

A return-to-work policy for follow up to a treatment episode for OUD is similar in concept to other chronic health conditions. This policy can set clear expectations for the employee's workplace conduct and responsibilities upon their return. Employee capabilities will largely be determined by their prescribed medical release and possible restrictions. An agreement should be reached with employee and employer input and include the following designations, at minimum:

- **Medical release form and potential restrictions**
- **Employer accommodations**
- **Periodic medical and job performance evaluations**
- **Designated length of agreement**

A well-constructed return-to-work policy can help support the employee in successfully reintegrating into the workplace. In some circumstances, employees returning to work after treatment of a SUD are protected under the Americans with Disabilities Act (ADA).

Legal Considerations

By addressing substance use and impairment in the workplace, an employer can positively impact their employees' lives while also protecting their business. As with many workplace interventions, there are also legal considerations. Employers should familiarize themselves with relevant laws, consult their labor and employment attorney, and if relevant, their labor relations team. The backbone of legally protecting any employer or employee are well-developed, compliant drug and alcohol and return-to-work policies. Careful and informed development of these policies in partnership with an employment attorney can help ensure policies comply with lawful guidelines and are fitting for the workplace. For a basic foundation for compliance, the Substance Abuse and Mental Health Services Administration provides 10 Steps for Avoiding Legal Problems at <https://www.samhsa.gov/workplace/legal/avoiding-problems>.

Substance use disorders (SUDs) are chronic health conditions. Similar to other chronic health conditions such as epilepsy, cancer, or diabetes, SUD fluctuates between exacerbation and remission. In the workplace, they should be treated in a similar fashion. Employers should keep in mind that symptoms of SUD can often mimic other health conditions.

What laws should employers be aware of?

- ➔ **Health Insurance Portability and Accountability Act (HIPAA)**
- ➔ **Americans with Disabilities Act (ADA)**
- ➔ **Family and Medical Leave Act (FMLA)**
- ➔ **Mental Health Parity and Addiction Equity Act (MHPAEA)**

Identification and Disclosure

In many cases, employers may be unaware of their employees' substance use behaviors, whether they are past or present. Employees may access EAP services, support groups, or consult their healthcare providers privately without any needed intervention from or disclosure to their employer. In these cases, the employer's role does not extend beyond ensuring that their health plan benefits and workplace policies are supportive for employees facing any chronic disease or health issue, including SUD. In other cases, employers may be made aware of an employee's substance use behaviors. Multiple laws and regulations exist that determine the nature of these occurrences and how each entity can proceed so that all parties' best interests are secured.

If an employee is suspected of being impaired in the workplace, employers should not immediately terminate or remove the employee from their position without a thorough assessment of the facts. A conversation with the employee can yield further information that will determine the next steps an employer may need to take. Employers may want to consider accommodations to protect their workforce and community. In some cases, this may involve reassigning an employee to another position for the day, and in others, it may involve taking further action. To confirm suspicion of impairment, employers should consider the objective

evidence and, if legally permitted, require drug testing. Consider that impairment in the workplace could be a result of legal and illegal drug use.

If an employee is suspected of having an SUD or ongoing addiction issue, it is important to proceed cautiously. Employees can have a substance use issue but never violate a written substance use policy, which is why it is crucial that employers focus on performance or behavior issues rather than perceived health condition symptoms. Despite any suspicions an employer may have, the Americans with Disabilities Act (ADA) does not allow employers to make disability-related inquiries or medical examinations of their employees unless they are “job-related and consistent with business necessity.” For example, questions about past drug use and rehabilitation or current prescription drug use are not permitted, except in specific situations during the post-offer, pre-hire phase before employment commences. Current illegal drug use is not a covered disability under the ADA.

If an employee self discloses that they have an SUD, employers ordinarily cannot fire the employee only based on that disclosure without an interactive dialogue and weighing of all relevant facts and regulations. Employers should maintain confidentiality and assist the employee in accessing the services necessary to support their recovery based on the employee’s requests and interactive processes.

Intervention and Confidentiality

When an employee has violated a substance use policy or self disclosed an SUD, employers should act in the best interest of the employee, as well as their business.

Generally, intervening with an employee who is suspected of misusing substances should focus on the effect their misuse has had on performance or behavior, rather than the act of using itself. Employers should always consider if the same discipline would be imposed on an employee who is not suspected of addiction or substance abuse versus those who are. The same processes should apply.

Employers are not required to terminate employees if workplace impairment or a violation of substance use policy has been identified. They can help their employees access appropriate treatment and support their recovery, so they can maintain their employment status. However, an employer may consider terminating an employee who is provided this opportunity under these circumstances, continues to violate workplace policies, and exhibits performance deficiencies.

Employees who are in treatment may have concerns about confidentiality. Again, in many cases, employees may get the help they need without the employer ever being made aware of their condition. In cases where the employer is made aware, employees’ confidentiality should be a priority. The ADA and FMLA limit the information that employers have access to regarding an employee’s disability or serious health condition. Additionally, certain entities covered under the Health Insurance Portability and Accountability Act (HIPAA) limits how personal health information is disclosed, secured, and used. Each of these regulations have specifications that are situationally based. In general, employers should limit the amount of information to the minimum necessary to administer sick leave and similar HR benefits. Employers should refer to their administrators as much as possible in handling workers’ compensation, wellness programs, or health plan processes. It is a best practice to obtain employee consent for any release of medical information as it applies to these decisions. When in doubt, consult legal counsel to ensure full compliance to all laws.

Discrimination and Reasonable Accommodation

Employees who are entering treatment or are in recovery, or who have family members in treatment, may be entitled to reasonable accommodations in the workplace. Accommodations may include the use of paid or unpaid leave, flexible scheduling, or modification of workplace duties.

The Americans with Disabilities Act (ADA) requires employers to provide equal opportunities and accommodations for employees with disabilities. When applied to substance use, current illegal drug users are not protected. However, individuals who have successfully completed a treatment program and are in recovery do qualify. Employees who are legally using prescribed or over-the-counter drugs as part of a disability may also be protected. Employers may be required to accommodate protected employees' job restrictions so that they can work safely and effectively. Furthermore, employers cannot fire, refuse to hire, or refuse to promote protected employees because of a disability.

In some cases, employees may need to take extended leave. The Family and Medical Leave Act (FMLA) permits these employees to go on unpaid leave for up to 12 weeks per year. Under the FMLA, treatment for substance use qualifies as a serious health condition, thus employees who are eligible must be granted a leave of absence.

Special Industry Considerations

Under federal and state guidelines, some industries may have specific regulations that apply to what they are required, able, or unable to do when addressing substance use in their workforce.

Employer Size and Type | These characteristics affect compliance with the Americans with Disabilities Act (ADA) and the Family and Medical Leave Act (FMLA.)

Safety- and Security-Sensitive Industries | These organizations are subject to drug-testing regulations from the U.S. Department of Transportation (DOT), U.S. Department of Defense (DOD), and Nuclear Regulatory Commission (NRC).

Labor Unions | Unions can play a major part in what actions employers can take in addressing substance and opioid use, per the National Labor Relations Act of 1935. Collective bargaining is an opportunity for employers and labor to come together to agree on benefits and policies for the union represented workforce.

Federal Agencies, Contractors, and Grantees | These entities are required to implement a drug-free workplace program under the Drug-free Workplace Act of 1988.

Appendix A: Terms to Know

Dependence	A state where the body adapts to the presence of a drug and presents withdrawal symptoms when drug use is reduced or discontinued.
Harm-Reduction	A treatment and prevention approach that encompasses individual and public health needs, aiming to decrease the consequences of addiction related problems. ² These can include needle exchanges and naloxone for overdose prevention.
Medication for Opioid Use Disorder (MOUD)	The medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. ³ MOUD is also commonly known as Medication for Addiction Treatment (MAT).
Misuse	The use of prescription opioids in any way other than as directed by a prescriber; the use of any opioid in any manner, situation, amount, or frequency that can cause harm to self or others.
Opioid Use Disorder (OUD)	A disorder characterized by loss of control of opioid use, risky opioid use, impaired social functioning, tolerance, and withdrawal. ^{3,1}
Overdose	A potentially fatal medical incident where a toxic amount of drugs, or a combination of, drugs overwhelms the body. When overdosing on opioids, breathing, blood pressure, and heart rate will all slow and can lead to coma or death. ³
Prevention	An approach on helping people develop the knowledge, attitudes, and skills they need to make good choices or change harmful behaviors related to opioid misuse and OUD.
Recovery	A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. ³
Remission	A medical term meaning a disappearance of signs and symptoms of the disease.
Return to Use	One or more instances of opioid misuse without a return of symptoms of OUD. A return to opioid use may lead to return of OUD symptoms. ³
Treatment	A process of diagnosing and treating individuals with OUD. Treatment can occur in a variety of settings and forms, and should always include options for Medication for Opioid Use Disorder (MOUD) and behavioral therapies. Treatment is a long term process.
Tolerance	Alteration of body's responsiveness to alcohol or other drugs such that higher doses are required to produce the same effect achieved during initial use. ³
Withdrawal	A series of symptoms ranging in severity that follow the absence of opioids in someone's system after prolonged exposure. These symptoms can include nausea, muscle cramping, depression, agitation, anxiety, and intense cravings.

Appendix B: Checklist

Before you Begin

- ✓ Educate yourself on the basics of opioids, addiction, and what it looks like in the workplace
- ✓ Recruit key decision makers in your workplace and engage them in the change process
- ✓ Consult an employment attorney and, if relevant, labor relations experts to advise you in reviewing and implementing current and future changes to opioids in the workplace

Getting your Data

- ✓ Identify what your data capabilities are and who you need to request your data from
- ✓ Consider what questions you have about your workplace and opioids, and request the corresponding measures from your data source
- ✓ Evaluate your results and determine what “story” your data tells
- ✓ Identify opportunities for improvement based on data analytics

Questions to Ask about Prevention:

- How often are members being exposed to opioids?
- Why are members being prescribed opioids?
- Are members receiving appropriate care to manage their pain?
- Are members who are exposed to opioids at risk?
- Are members overdosing on opioids?

Questions to Ask about Treatment and Recovery:

- How many members have been diagnosed with a substance use disorder?
- Are members with substance use disorder accessing treatment?

Evaluating your Healthcare Benefits

- ✓ Compare your current healthcare benefit offerings to those discussed in this toolkit
- ✓ Determine necessary additions, subtractions, or adjustments to your offerings
- ✓ Meet with your health plan partner on what changes you would like to make and work with them to implement them



Recommendations for Prevention:

- Help employees manage pain
- Cover screening in primary care offices
- Cover site-of-use disposal
- Offer employee assistance programs (EAP)

Recommendations for Treatment and Recovery:

- Provide access for inpatient and outpatient care
- Cover medication for opioid use disorder
- Provide access to behavioral and mental health services
- Cover naloxone to reduce mortality
- Improve access to behavioral healthcare through telemedicine
- Consider centers of excellence and alternative payment models

Adjusting your Workplace Policies

-  Compare your current workplace policies to those discussed in this toolkit
-  Consider making the necessary adjustments to your policies




Recommendations for Prevention:

- Educate employees and supervisors
- Create a culture of support
- Develop a workplace substance use policy
- Implement effective and privacy-sensitive drug testing

Recommendations for Treatment and Recovery:

- Offer leaves of absence and flexible scheduling
- Provide support group resources
- Develop a return to work policy

Staying Engaged

-  Review your data, at minimum, on a yearly basis to determine positive or negative trends
-  Identify any changes to benefits or workplace policies based on new trends or clinical advancements
-  Engage with other healthcare stakeholders to represent the employer perspective and stay up to date on innovations and changes in this area

Appendix C: Data Specifications

Below are the data specifications for measures recommended in the toolkit. Employers should reference this sheet when requesting their data from their data vendor, health plan, pharmacy benefit manager, or insurance broker. Some measures may have standardized definitions from nationally accredited organizations, while others depend on your data vendor's reporting. Either way, it is important for employers to be aware of the parameters that define each measure in order to accurately interpret their data.

Medical and Pharmacy Summary Analytics	
Enrollment Data	Number of members by type (employees/spouses/dependents) Average family size Percentage of males vs. females Average age
Total Expenditures	Medical and pharmacy spending including out-of-pocket expenses for members
Top Conditions and Medications	Prevalence Total expenditures
Total Mental Health and Substance Use Disorder Expenditures	Medical and pharmacy spending

Employers should also consider and discuss how this data can be broken down, or further stratified. Included below are a list of standard stratifications. Some measures may benefit from additional stratifications. Other helpful measures include comparison of workplace data metrics to national, state, regional, and industry benchmarks (if available), as well as total cost per member, condition, or prescriptions.

Many measures exclude certain medical conditions such as cancer and end-of-life care, but there may be other exclusions to consider as well. Employers should discuss these exclusions with their data vendor.

Standard Stratifications
Gender
Age group
Employee type (hourly/salaried)
Relationship to Employee (self/spouse/dependent)
In network/out of network
Health plan type

Additional Data to Consider
Data compared to national, state, local, and industry benchmarks
Total cost per member
Total cost per condition
Total cost per prescription

Prevention

How often are members being exposed to opioids?			
*Opioids Prescriptions	Rate per 1,000 of opioid prescriptions among members 18 years and older		
	Numerator: Number receiving prescription opioids during the measurement year	Denominator: Members 18 years and older	Stratifications: Standard Additional <ul style="list-style-type: none"> Type of Opioid Length of Prescription Long-Acting vs Short-Acting

Why are members being prescribed opioids?			
*Top Conditions Opioids are Most Prescribed for	Top conditions that opioids are most prescribed for among members 18 years and older		
	Numerator: Number receiving prescription opioids for each condition type	Denominator: Members 18 years and older who received prescription opioids during the measurement year	Stratifications: Standard Additional: <ul style="list-style-type: none"> Prescription Rate per Condition

Are members receiving appropriate care to manage their pain?			
Follow Up Visit Quarterly https://www.cdc.gov/drugoverdose/pdf/prescribing/CDC-DUIP-QualityImprovementAndCareCoordination-508.pdf	Percentage of patients on long-term opioid therapy who have a follow-up visit at least quarterly		
	Numerator: Number of patients who had at least one in-person follow-up visit with the prescribing clinician at least quarterly	Denominator: Number of patients in an outpatient panel of patients 18 years of age or older with ≥ 60 days' supply of opioids within a quarter	Stratifications: Standard

*Indicates measures that do not have national standardized definitions

Are members receiving appropriate care to manage their pain?			
Quarterly Pain and Functional Assessments https://www.cdc.gov/drugoverdose/pdf/prescribing/CDC-DUIP-QualityImprovementAndCareCoordination-508.pdf	Percentage of patients on long-term opioid therapy who had at least quarterly pain and functional assessments		
	Numerator: Number of patients with documented pain and functional assessments using a validated clinical assessment tool at least quarterly	Denominator: Number of patients in an outpatient panel of patients 18 years of age or older with ≥ 60 days' supply of opioids within a quarter	Stratifications: Standard
Referral for Nonpharmacologic Therapy https://www.cdc.gov/drugoverdose/pdf/prescribing/CDC-DUIP-QualityImprovementAndCareCoordination-508.pdf	Percentage of patients with chronic pain who had at least one referral or visit to nonpharmacologic		
	Numerator: Number of patients who had at least one referral to nonpharmacologic therapy	Denominator: Number of patients in an outpatient panel of patients 18 years of age or older with chronic pain	Stratifications: Standard

Are members who are prescribed opioids at risk?			
Use of Opioids at High Dosage https://www.ncqa.org/hedis/measures/use-of-opioids-at-high-dosage/	Percentage of members 18 years and older who received prescription opioids at a high dosage		
	Numerator: Number receiving prescription opioids at high dosage (average morphine equivalent dose [MED] > 120 mg) for ≥ 15 days during the measurement year	Denominator: Members 18 years and older who received prescription opioids during the measurement year	Stratifications: Standard

***Indicates measures that do not have national standardized definitions**

Are members who are prescribed opioids at risk?			
*Opioid Total Days Covered	Average number of days covered by an opioid prescription for members 18 years and older		
	Numerator: Total number of days that all opioids claims covered	Denominator: Members 18 years and older who received prescription opioids during the measurement year	Stratifications: Standard
*Opioid Lag Days Between Rx	Average number of days lapsed between opioid prescriptions for members 18 years and older		
	Numerator: Total number of days passed between the current prescription fill date and the previous prescription's run-out date	Denominator: Members 18 years and older who received prescription opioids during the measurement year	Stratifications: Standard
Use of Opioids from Multiple Providers https://www.ncqa.org/hedis/measures/use-of-opioids-from-multiple-providers/	For members 18 years and older, the percentage receiving prescription opioids for > 15 days during the measurement year who received opioids from multiple prescribers, multiple pharmacies, or multiple providers and pharmacies; three rates are reported		
	Numerator: Number receiving prescription opioids for ≥15 days during the measurement year who received opioids from multiple prescribers, multiple pharmacies, or multiple providers and pharmacies	Denominator: Members 18 years and older	Stratifications: Standard

Are members overdosing on opioids?			
*Opioid Overdose Rescue (Naloxone) Prescriptions	Rate per 1,000 members that have been prescribed an overdose reversal drug (Narcan/Naloxone) among members 18 years and older		
	Numerator: Number prescribed an overdose reversal drug in the measurement year	Denominator: Members 18 years and older	Stratifications: Standard

***Indicates measures that do not have national standardized definitions**

Are members overdosing on opioids?			
*Opioid Overdose/ Poisoning	Rate per 1,000 members of opioid overdose/poisoning among members 18 years and older; two rates are reported		
	Numerator: Number of (1) patients with an opioid overdose/poisoning or (2) total overdoses/poisonings	Denominator: Members 18 years and older	Stratifications: Standard
*ER Visits due to Overdose	Rate per 1,000 of members that have had a visit to the emergency room (ER) due to overdose/poisoning among members 18 years and older who received prescription opioids		
	Numerator: Number of members who had an ER visit due to an overdose/poisoning	Denominator: Members 18 years and older who received prescription opioids	Stratifications: Standard
Concurrent Use of Opioids and Benzodiazepines https://www.pqaalliance.org/assets/Measures/PQA%20Opioid%20Core%20Measure%20Set%20Description%202019-02-22.pdf	Percentage of members 18 years and older with concurrent use of prescription opioids and benzodiazepines during the measurement year		
	Numerator: Number with concurrent use of opioids and benzodiazepines for 30 or more cumulative days during the measurement year	Denominator: Members 18 years and older with multiple prescription claims for opioids with unique dates of service, for which the sum of the days' supply is 15 or more days	Stratifications: Standard

Treatment and Recovery

How many members have been diagnosed with a substance use disorder?			
*Substance Use Disorder Diagnosis (Dx)	Rate per 1,000 of members 18 years and older who have been diagnosed with substance use disorder (SUD)		
	Numerator: Number with substance use disorder (SUD) diagnosis	Denominator: Members 18 years and older	Stratifications: Standard
*Opioid Use Disorder Diagnosis (Dx)	Rate per 1,000 of members 18 years and older who have been diagnosed with opioid use disorder (OUD)		
	Numerator: Number with opioid use disorder (OUD) diagnosis	Denominator: Members 18 years and older	Stratifications: Standard

***Indicates measures that do not have national standardized definitions**

How many members have been diagnosed with a substance use disorder?			
*Alcohol Use Disorder Diagnosis (Dx)	Rate per 1,000 of members 18 years and older who have been diagnosed with alcohol use disorder (AUD)		
	Numerator: Number with alcohol use disorder (AUD) diagnosis	Denominator: Members 18 years and older	Stratifications: Standard

Are members with a substance use disorder getting treatment?			
Identification of Alcohol and Other Drug Services https://www.ncqa.org/hedis/measures/identification-of-alcohol-and-other-drug-services/	Number and percentage of members who had a service for alcohol and other drug (AOD) abuse or dependence (i.e., a claim with both a diagnosis of AOD abuse or dependence and a specific AOD-related service) during the measurement year		
	Numerator: Number who had a service for substance abuse or dependence	Denominator: Members 18 years and older with substance abuse or dependence diagnosis during the measurement year	Stratifications: Standard
Use of Pharmacotherapy for Opioid Use Disorder http://www.qualityforum.org/qps/3400	Percentage of members ages 18 to 64 with an OUD who filled a prescription for or were administered or ordered an FDA-approved medication for the disorder during the measure year. The measure will report any medications used in medication-assisted treatment of opioid dependence and addiction and four separate rates representing the following types of FDA-approved drug products: buprenorphine; oral naltrexone; long-acting, injectable naltrexone; and methadone.		
	Numerator: Number who filled a prescription for or were administered or ordered an FDA-approved medication for the disorder during the measure year	Denominator: Number of members ages 18 to 64 with at least one encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other) at any time during the measurement year	Stratifications: Standard Additional: • Duration of Use Per Prescription

***Indicates measures that do not have national standardized definitions**

Are members with a substance use disorder getting treatment?

<p>Counseling on Psychosocial and Pharmacologic Treatment Options for Opioid Addiction</p> <p>https://aspe.hhs.gov/report/review-medication-assisted-treatment-guidelines-and-measures-opioid-and-alcohol-use/e-summary-medication-assisted-treatment-quality-measures</p>	<p>Percentage of patients 18 years and older with a diagnosis of current opioid addiction who were counseled regarding psychosocial and pharmacologic treatment options for opioid addiction with the 12-month reporting period</p>		
	<p>Numerator: Number counseled regarding psychosocial and pharmacologic treatment options for opioid addiction with the 12-month reporting period</p>	<p>Denominator: Members 18 years and older with a diagnosis of current opioid addiction</p>	<p>Stratifications: Standard</p>
<p>Follow-Up After High Intensity Care for Substance Use Disorder</p> <p>https://www.ncqa.org/wp-content/uploads/2019/02/20190208_06_FUI.pdf</p>	<p>Percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder (SUD) that result in a follow-up visit or service for SUD among members 13 years and older</p>		
	<p>Numerator: Number of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of SUD that result in a follow-up visit or service for SUD</p>	<p>Denominator: Members 13 years and older with a diagnosis of current opioid addiction</p>	<p>Stratifications: Standard</p>

Appendix D: Resources

Want to learn more about opioids and addiction?

US Surgeon General's Spotlight on Opioids

https://addiction.surgeongeneral.gov/sites/default/files/OC_SpotlightOnOpioids.pdf

"Prevention and Treatment of Opioid Misuse and Addiction: A Review" from the Journal of the American Medical Association (JAMA)

<https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2716982>

Substance Abuse and Mental Health Service Administration's (SAMHSA) Website

<https://www.samhsa.gov/>

Need to find help for yourself, a loved one, or an employee?

Addiction Treatment Openings in Kentucky

<https://findhelpnowky.org/>

Addiction Treatment Openings across the US

<https://findtreatment.samhsa.gov/>

Help finding treatment and questions about treatment or recovery

1-833-8KY-HELP (1-833-859-4357)

Steps to finding Quality Treatment

<https://store.samhsa.gov/system/files/pep18-treatment-loc.pdf>

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²¹U.S. Department of Health and Human Services (2019, May). Pain Management Best Practices Inter-Agency Task Force Report: Up-dates, Gaps, Inconsistencies, and Recommendations. Retrieved from U. S. Department of Health and Human Services website: <https://www.hhs.gov/ash/advisory-committees/pain/reports/index.html>

²²Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2017

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